

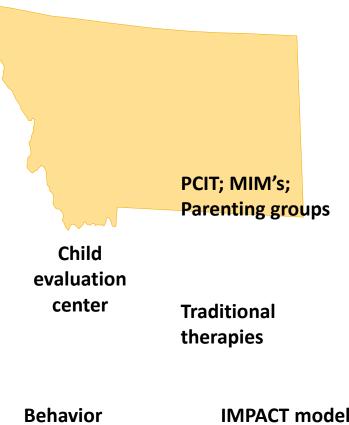
Who is Southwest Montana Community Health Center?

- 30 year old FQHC
- Level 3 PCMH-NCQA at Dillon and Butte clinic sites
- Serve Southwest Corner of Montana; Silver Bow, Madison, and Beaverhead counties
- Provide primary medical care, behavioral health, pharmacy, dental, and care management
- Serve approximately 14,000
- 60,000 visits annually
- Top diagnosis=depression
 - 2,117 patients with depression diagnosis
 - 2,517 patients with other mental health diagnosis (anxiety, PTSD, ADD, substance depend)



Southwest Montana Community Health Center

- All adult patients are screened annually with PHQ-2; if either questioned answered positive a full PHQ-9 is given.
- PCP treats appropriately and refers to behavioral health as indicated.
- Collaborative Care (IMPACT) model is used with stepped care approach if indicated.
- Targeting depressed adults.
- Interdisciplinary team includes: depression care managers, consulting psychiatrist, primary care provider, and behavioral health specialists
- Services include assessment, development of treatment plans and self-management goals, medication management, and BH therapy as needed
- Other behavioral health interventions with all patients as indicated.



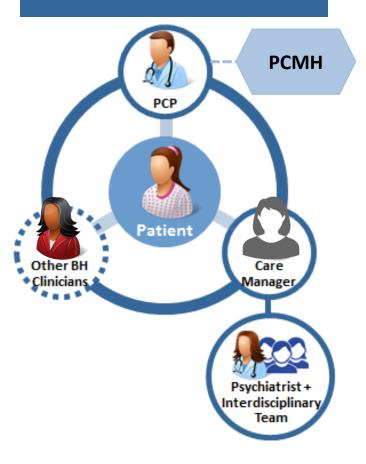
Modification

IMPACT model



Collaborative Care Team Roles and Responsibilities

Collaborative Care Model



Role	Description
Patient	 Member of identified target population, focusing on higher need populations Active participant in treatment
PCP	 Patient identification and referral Works in consultation with care manager Oversees all aspect of patient's care May be embedded in a PCMH
Care Manager	 Behavioral health professional embedded in PCP office Coordinates Collaborative Care Team Performs all care management tasks
Psychiatrist + Interdisciplinary Team	 Supports and collaborates with PCP and care manager Consults on patients who are clinically challenging or need specialty behavioral health services
Other BH Clinicians	 Embedded in PCP office or in community Supports PCP and care manager May see patients for in-person consultations

PCP conducts initial assessments and identifies patients in need of behavioral health therapy and enhanced care management



Care manager works with patient and PCP to develop treatment plan; PCP continues to manage patient's medical care



PCP and care manager consult and collaborate with a psychiatrist and interdisciplinary team on patient diagnoses and treatment plans



Positive patient outcomes!



Once patient is considered stable, PCP and care manager work together to develop relapse prevention plan and continuously monitor patient



PCP, care manager, and onsite behavioral health providers continue to manage and monitor patient's care, consulting psychiatrist and interdisciplinary team weekly or as needed